UPDATES FOR REQUEST FOR PROPOSALS FOR
CalWORKs and HFSS

1) Bid Numbers for Request For Proposals:
   DMH 072816B1 - California Work Opportunity and Responsibility To Kids (CalWORKs) Participants
   DMH 072116B1 -Homeless Family Solutions System (HFSS) Services

2) CalWORKs – Statement of Work
   Exhibit 15 – QUALITY ASSURANCE REIMBURSABLE ACTIVITIES GUIDE (see attached)

3) Forms and Instructions (see attached):
   CalWORKs RFP
   1. Exhibit 14 – Budget Form
   2. Exhibit 14 – Budget Narrative Instructions
   3. Exhibit 15 – CalWORKs Program Description

   HFSS RFP
   1. Exhibit 2 – Budget Form
   2. Exhibit 2 – Budget Narrative Instructions
   3. Exhibit 3 – HFSS Program Description

County of Los Angeles
Department of Mental Health

REQUIRED FORMS - EXHIBIT 14

CalWORKs Mental Health Supportive Services

CalWORKs PROGRAM BUDGET FORM

PROVIDER/PROPOSER NAME: _____

Service Area: _____

PROVIDER SITE STAFFING			FTEs	AMOUNT	% of Total Amount Requested
A. PERSONNEL SALARIES (Require 70% Minimum)					
	1	**PROGRAM STAFF**			
	a	Psychologist/MSW/LCSW/MFT (Lic./Reg./Waiv'd.) MH Clinical Nurse Specialist (CSN)			#DIV/0!
	b	RN, LVN, Psych. Tech.			#DIV/0!
	c	MH Rehabilitation Specialist			#DIV/0!
	d	Mental Health Related B.A. or 2 yrs. MH Experience - not licensed			#DIV/0!
	e	CONSULTANT STAFF *(Professional Services)*			#DIV/0!
	f	ADMINISTRATION/SUPPORT			#DIV/0!
		Total Salaries and Wages (lines 1a-d, 2 and 3)		$ -	#DIV/0!
		Employee Benefits			#DIV/0!
		TOTAL PERSONNEL SALARIES & EMPLOYEE BENEFITS/FTEs	0.00	$ -	#DIV/0!
B. SERVICES AND SUPPLIES (S&S)					
	1	Office Supplies			#DIV/0!
	2	Mileage			#DIV/0!
	3	Training			#DIV/0!
	4	Other (Specify)			#DIV/0!
		TOTAL SERVICES AND SUPPLIES (lines 1-3)		$ -	#DIV/0!
C. EQUIPMENT ***(Purchased with a Unit Value $5,000 or more)***					#DIV/0!
D. FACILITY COSTS					#DIV/0!
		SUBTOTAL PERSONNEL/S&S/EQUIPMENT/FACILITY COSTS		$ -	#DIV/0!
E. INDIRECT ADMINISTRATIVE OVERHEAD					#DIV/0!
AMOUNT - SERVICE AREA ALLOCATION PER AWARD		**PROPOSER TOTAL AMOUNT**	**0.00**	**$ -**	**#DIV/0!**

REQUIRED FORMS – EXHIBIT 14

CalWORKs Mental Health Supportive Services

BUDGET INSTRUCTIONS

BUDGET NARRATIVE AND JUSTIFICATION

Provider/Proposer must provide a narrative explaining its proposed budget costs and a justification for the costs.

GENERAL INFORMATION

The budget must clearly indicate that a viable program will be operating within the timeframe allotted for the program. **The budget should be based on the Service Area Allocation per Award.** The Budget Narrative, an attachment to the Budget Form, must provide the formulas (calculations) showing how each dollar amount that appears on the Budget Form was calculated. All amounts are to be rounded off to the nearest dollar.

Please Note:
Following are explanations of the allowable line item categories and examples of how line item amounts are calculated. The examples show how formulas on the required Budget Narrative and Justification should look.

A. PERSONNEL SALARIES (Require 70% Minimum)

1. **Program Staff (Items a-d)**
   - Indicate the staff position and salary for each staff person proposed for program.
   - Indicate the percentage of Employee/Fringe Benefits for each staff classification. This includes FICA, unemployment insurance, workers' compensation, and health insurance. List total Employee/Fringe Benefit Package costs.
   - Add the benefit dollar amount to the salary dollar amount to arrive at the combined salary/benefit for each classification.

     EXAMPLE:

     Salary: Project Coordinator @ 4000 mo. X 12 mos. = $48,000

     Employment Benefits: 26% X $48,000 = $12,480

     Total Project Coordinator salary and benefits: $48,000 + $12,480 = $60,480

2. **Consultants (Professional Services)**
   - List the names (if known) and type of consultants to be hired, the annual number of consultations, and the consultation rate. For example:

     EXAMPLE:

     Curriculum Consultant: 50 hours at $200/hour = $10,000

REQUIRED FORMS – EXHIBIT 14

CalWORKs Mental Health Supportive Services

BUDGET INSTRUCTIONS

3. **Administration/Support**
   - Indicate the staff position and salary for each staff person proposed for the program.
   - Indicate the percentage of Employee/Fringe Benefits for each staff classification. This includes FICA, unemployment insurance, workers' compensation, and health insurance. List total Employee/Fringe Benefit Package costs for each staff position.
   - Add the benefit dollar amount to the salary dollar amount to arrive at the combined salary/benefit for each classification.

     EXAMPLE:

     Salary: Project Coordinator @ $2500 mo. X 12 mos. = $30,000

     Employment Benefits: 26% X $30,000 = $7800

     $30,000 + $7800 = Total Project Coordinator salary and benefits)

B. SERVICES AND SUPPLIES COSTS (S&S)

Costs for production/re-production of teaching materials, mailing, office supplies, mileage related to the program may be included if they are not included in the overall administrative costs of the program and can be identified as such for invoicing purposes.

1. **Office Supplies**
   - Specify the annual costs for the duration of the program.

   EXAMPLE:

   Training and Presentation Supplies @100 month X 12 months = $1200

2. **Mileage**
   - Specify the total annual proposed cost requiring travel mileage and the basis for computation. Mileage must be computed in accordance with the County's prevailing Rate Schedule.

     EXAMPLE:

     Rate ($0.51) x Number of Miles = Total Mileage Cost

3. **Other (i.e.) Production /re-production of teaching materials**
   - Specify the annual cost for the duration of the program.

REQUIRED FORMS – EXHIBIT 14

CalWORKs Mental Health Supportive Services

BUDGET INSTRUCTIONS

C. EQUIPMENT

"Equipment" means non-expendable personal property, each item of which has (a) a useful life in excess of three years, and (b) a value in excess of Five Thousand Dollars ($5,000).

- Purchases: Identify equipment to be purchased, a justification statement for the purchase, and the cost of each piece of equipment.

- Equipment Leases – Identify equipment to be leased, a justification statement for all leased equipment, and the cost of each lease.

D. FACILITY COSTS

Facility Rent/Lease

- Specify the gross square footage, monthly and yearly gross cost, monthly and yearly cost per square foot.
- If facility is currently being rented, attach a copy of the current lease or rental agreement. Rents and purchase costs applied to the contract will be compared to the guidelines issued by the County of Los Angeles - Internal Services Department for evaluating rent costs in the current budget.

E. INDIRECT COSTS

Administrative support and other indirect costs are those incurred for the common benefit of the organization's total contracted program and are not directly or readily attributable to a previously specified direct cost. Allowable administrative costs include accounting, budgeting, financial screening, general administrative personnel, information system, office services, and other such similar services. These costs must be reasonable, be equitably allocated and compliant with federal cost allocation principles. Consult with your accountant. Administrative costs are allowable to the extent they are: 1) reasonable and 2) related to the services provided by the providers.

- **ADMINISTRATIVE COSTS**

  Administrative costs are the indirect costs related to the implementation and operation of the program. Such costs must be reasonable and include a formula on how the cost was calculated.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
CalWORKs PROGRAM DESCRIPTION

EXHIBIT 15 - PROGRAM DESCRIPTION

GENERAL INSTRUCTIONS: Include Program Description with Negotiation Package submission. Insert after Schedule 2 - Contract Application.

The application must include a Program Description Exhibit for each program to be funded by the County of Los Angeles Department of Mental Health (LACDMH). The template for the Program Description Exhibit is included on Page 2.

For CalWORKs providers, a Program Description is required on an annual basis when submitting the Negotiation Package. The annual Negotiation Package submission meets the Memorandum of Understanding guidelines required by the Department of Public Social Services for the CalWORKs Program.

COMPLETE THE QUESTIONS ON PAGES 2-5. IF NOT APPLICABLE, ENTER N/A.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
CalWORKs PROGRAM DESCRIPTION

PROGRAM DESCRIPTION

1. CalWORKs Program Name:

2. Fiscal Year:

3. Legal Entity Name:

4. Legal Entity Number:

   Enter the State/County assigned Legal Entity Number. New Service providers are to enter "TBD" (To Be Determined).

5. Please complete the following table:

Provider No.	Service Area	Supervisorial District(s)	Number of CalWORKs slots available	Number of unique clients to be served	Average cost per unique client

6. List procedures in the event the program reaches its capacity at any point during the proposed contract term.

7. What is the procedure for managing referrals and continuity of care?

8. Special Characteristics of the Population to be served:
   a. Identify the demographics of the geographic area to be served:

   b. Percentage of monolingual non-English speaking clients to be served under this program?

Language	Percentage

9. Public Transportation Access
    a. List each facility site and, for each site, describe the public access to the site. Be specific as to the distance of the closest bus, light rail, subway, or other public transportation stop.

10. Staff Training and Supervision.
    a. Describe the nature, frequency, and method of supervision for all staff, including master's-level student interns and volunteers.

    b. How are new staff oriented and trained to provide CalWORKs mental health services?

    c. Is training offered in specific topics, such as CalWORKs GAIN documentation, employment-focused treatment, or non-violent crisis intervention that are required for staff to attend?

    d. Are there in-service trainings to increase staff awareness of and sensitivity to ethnic and cultural issues?

11. Program Description: Provide a program description including, but not limited to the following topics:

    a. For a newly funded CalWORKs program, describe the implementation plan and timeline, including effective dates for the beginning of start-up work and the availability of service delivery.

    b. Explain the staffing profile that is required to meet the linguistic and/or cultural needs of the target population to be served.

    c. Describe services to be provided, including the following:

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
CalWORKs PROGRAM DESCRIPTION

i. Intake Procedure: Describe the intake procedure for CalWORKs participants. How do GAIN Services Workers (GSWs) contact the centralized appointment desk to obtain an assessment appointment? How is facsimile contact from GSWs handled? Explain intake procedure and scheduling of assessment appointments within the DPSS priority levels. Are there specific hours to accept new intakes?

ii. Outreach and Engagement: Describe the program's strategies to engage clients prior to their scheduled intake appointment? If community based outreach services are necessary in those areas where referrals are low and/or the community need for education and engagement efforts remain high, what efforts are employed?

iii. Which evidence-based practices (EBP) are utilized specifically for the CalWORKs population? How is staff trained on the EBPs? What outcomes are collected to ensure efficacy of the identified EBPs?

iv. Describe your agency's management of CalWORKs participants' access to psychiatric evaluations and medication support services.

v. Describe how case management, linkages, peer support, and other support services are provided?

vi. Describe how crisis management services (telephone 24/7 or face-to-face) will be provided, both during and after business hours.

vii. Describe dis-enrollment procedures, including the minimum of three attempts at contact prior to disenrollment (i.e. telephone call, letter, home visit, etc.), referrals for continuity of care, and communication with GAIN.

viii. Describe the role and functions of any partners, including how substance use and domestic violence treatment and/or linkage is handled at your agency.

ix. Describe how Supported Employment Individual Placement and Support Services will be provided to CalWORKs participants. Include the referral process, the role and functions of supported employment staff, and employment-related community partners.

x. Provide any additional details that you believe are pertinent about the program.

County of Los Angeles
Department of Mental Health

REQUIRED FORMS - EXHIBIT 2

Homeless Family Solutions System

HFSS PROGRAM BUDGET FORM

PROVIDER/PROPOSER NAME: _____

Service Area: _____

PROVIDER SITE STAFFING			FTEs	AMOUNT	% of Total Amount Requested
A. PERSONNEL SALARIES (Require 70% Minimum)					
	1	**PROGRAM STAFF**			
	a	Psychologist/MSW/LCSW/MFT (Lic./Reg./Waiv'd.) MH Clinical Nurse Specialist (CSN)			#DIV/0!
	b	RN, LVN, Psych. Tech.			#DIV/0!
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	d	Mental Health Related B.A. or 2 yrs. MH Experience - not licensed			#DIV/0!
	e	CONSULTANT STAFF *(Professional Services)*			#DIV/0!
	f	ADMINISTRATION/SUPPORT			#DIV/0!
		Total Salaries and Wages (lines 1a-d, 2 and 3)		$ -	#DIV/0!
		Employee Benefits			#DIV/0!
		TOTAL PERSONNEL SALARIES & EMPLOYEE BENEFITS/FTEs	0.00	$ -	#DIV/0!
B. SERVICES AND SUPPLIES (S&S)					
	1	Office Supplies			#DIV/0!
	2	Mileage			#DIV/0!
	3	Training			#DIV/0!
	4	Other (Specify)			#DIV/0!
		TOTAL SERVICES AND SUPPLIES (lines 1-3)		$ -	#DIV/0!
C. EQUIPMENT ***(Purchased with a Unit Value $5,000 or more)***					#DIV/0!
D. FACILITY COSTS					#DIV/0!
		SUBTOTAL PERSONNEL/S&S/EQUIPMENT/FACILITY COSTS		$ -	#DIV/0!
E. INDIRECT ADMINISTRATIVE OVERHEAD					#DIV/0!
AMOUNT - SERVICE AREA ALLOCATION PER AWARD		**PROPOSER TOTAL AMOUNT**	**0.00**	**$ -**	**#DIV/0!**

REQUIRED FORMS – EXHIBIT 2

Homeless Family Solutions System

BUDGET INSTRUCTIONS

BUDGET NARRATIVE AND JUSTIFICATION

Provider/Proposer must provide a narrative explaining its proposed budget costs and a justification for the costs.

GENERAL INFORMATION

The budget must clearly indicate that a viable program will be operating within the timeframe allotted for the program. **The budget should be based on the Service Area Allocation per Award.** The Budget Narrative, an attachment to the Budget Form, must provide the formulas (calculations) showing how each dollar amount that appears on the Budget Form was calculated. All amounts are to be rounded off to the nearest dollar.

Please Note:
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A. PERSONNEL SALARIES (Require 70% Minimum)

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   - Indicate the staff position and salary for each staff person proposed for program.
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     EXAMPLE:

     Salary: Project Coordinator @ 4000 mo. X 12 mos. = $48,000

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2. **Consultants (Professional Services)**
   - List the names (if known) and type of consultants to be hired, the annual number of consultations, and the consultation rate. For example:

     EXAMPLE:

     Curriculum Consultant: 50 hours at $200/hour = $10,000

REQUIRED FORMS – EXHIBIT 2

Homeless Family Solutions System

BUDGET INSTRUCTIONS

3. **Administration/Support**
   - Indicate the staff position and salary for each staff person proposed for the program.
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     Salary: Project Coordinator @ $2500 mo. X 12 mos. = $30,000

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     $30,000 + $7800 = Total Project Coordinator salary and benefits)

B. SERVICES AND SUPPLIES COSTS (S&S)

Costs for production/re-production of teaching materials, mailing, office supplies, mileage related to the program may be included if they are not included in the overall administrative costs of the program and can be identified as such for invoicing purposes.

1. **Office Supplies**
   - Specify the annual costs for the duration of the program.

   EXAMPLE:

   Training and Presentation Supplies @100 month X 12 months = $1200

2. **Mileage**
   - Specify the total annual proposed cost requiring travel mileage and the basis for computation. Mileage must be computed in accordance with the County's prevailing Rate Schedule.

     EXAMPLE:

     Rate ($0.51) x Number of Miles = Total Mileage Cost

3. **Other (i.e.) Production /re-production of teaching materials**
   - Specify the annual cost for the duration of the program.

C. EQUIPMENT

REQUIRED FORMS – EXHIBIT 2

Homeless Family Solutions System

BUDGET INSTRUCTIONS

"Equipment" means non-expendable personal property, each item of which has (a) a useful life in excess of three years, and (b) a value in excess of Five Thousand Dollars ($5,000).

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E. INDIRECT COSTS

Administrative support and other indirect costs are those incurred for the common benefit of the organization's total contracted program and are not directly or readily attributable to a previously specified direct cost. Allowable administrative costs include accounting, budgeting, financial screening, general administrative personnel, information system, office services, and other such similar services. These costs must be reasonable, be equitably allocated and compliant with federal cost allocation principles. Consult with your accountant. Administrative costs are allowable to the extent they are: 1) reasonable and 2) related to the services provided by the providers.

- **ADMINISTRATIVE COSTS**

  Administrative costs are the indirect costs related to the implementation and operation of the program. Such costs must be reasonable and include a formula on how the cost was calculated.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
HFSS PROGRAM DESCRIPTION

EXHIBIT 3: PROGRAM DESCRIPTION

GENERAL INSTRUCTIONS: Include Program Description with Negotiation Package submission. Insert after Schedule 2 – Contract Application.

The application must include a Program Description Exhibit for each program to be funded by the County of Los Angeles Department of Mental Health (LACDMH). The template for the Program Description Exhibit is included on Page 2.

For HFSS providers, a Program Description is required on an annual basis when submitting the Negotiation Package. The annual Negotiation Package submission meets the Memorandum of Understanding guidelines required by the Department of Public Social Services for the HFSS Program.

COMPLETE THE QUESTIONS ON PAGES 2-5. IF NOT APPLICABLE, ENTER N/A.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
HFSS PROGRAM DESCRIPTION

PROGRAM DESCRIPTION

1. HFSS Program Name:

2. Fiscal Year:

3. Legal Entity Name:

4. Legal Entity Number:

   Enter the State/County assigned Legal Entity Number. New Service providers are to enter "TBD" (To Be Determined).

5. Please complete the following table:

Provider No.	Service Area	Supervisorial District(s)	Number of unique clients to be served

6. Special Characteristics of the Population to be served:
   a. Identify the demographics of the geographic area to be served:

   b. Percentage of monolingual non-English speaking clients to be served under this program?

Language	Percentage

7. Public Transportation Access
   a. List each facility site and, for each site, describe the public access to the site. Be specific as to the distance of the closest bus, light rail, subway, or other public transportation stop.

8. Staff Training and Supervision.

a. Describe the nature, frequency, and method of supervision for the licensed clinical staff to be co-located at the Family Solutions Center.

b. Are there in-service trainings to increase staff awareness of and sensitivity to ethnic and cultural issues?

9. Program Description: Provide a program description including, but not limited to the following topics:

a. For HFSS providers, describe the implementation plan and timeline, including effective dates for the beginning of start-up work and the availability of service delivery.

b. Describe services to be provided, including the following:
   i. How do you coordinate referrals with DPSS; link participants to mental health treatment; provide mental health crisis intervention and provide training and consultation at the local Family Solutions Center?

   ii. Describe how case management, linkages, and other support services are provided?

   iii. Describe how the mental health clinician collaborates with substance use disorder and domestic violence services providers.

   iv. Provide any additional details that you believe are pertinent about the program.

CalWORKs

Statement of Work

Exhibit 15

EXHIBIT 15

QUALITY ASSURANCE REIMBURSABLE ACTIVITIES GUIDE

Initially Effective February 1, 2003

Revised November 21, 2008

DMH Financial Services Bureau

Reimbursement and Audit Support Division

Revenue Recovery Section

And

Program Support Bureau

Quality Assurance

QUALITY ASSURANCE REIMBURSABLE ACTIVITIES GUIDE

Initially Effective February 1, 2003
Revised November 21, 2008

DMH Financial Services Bureau
Reimbursement and Audit Support Division
Revenue Recovery Section
and
Program Support Bureau
Quality Assurance

Marvin J. Southard, DSW
Director

TABLE OF CONTENTS

QUALITY ASSURANCE

ACTIVITIES

QA OVERSIGHT ACTIVITIES

Initial Implementation:

- Effective January 1, 2003, the Los Angeles County Department of Mental Health began collecting and claiming Medi-Cal Quality Assurance (QA) Oversight Activities.

In General, what are QA Oversight Activities:

- They are indirect activities defined by the Federal government that assist a Local Mental Health Plan in insuring and improving the quality of care delivered by its organization.
- They are activities that are clearly distinct from the other indirect activities familiar to staff of the Department such as Medical Administrative Activities (MAA) and Community Outreach Services (COS).
- They are similar to these other indirect activities in that they are not provided as a service to or in relation to a client of the Department.

Who can claim:

- As the Local Mental Health Plan for specialty mental health services in Los Angeles County, the Department of Mental Health can claim the cost of certain County QA oversight activities to the Federal government.
- Licensed Skilled Professional Medical Personnel (SPMP) is defined by the Federal government as professionals who hold a current California license in one of these fields: physician, psychiatrist, psychologist, RN, LCSW, MFT and pharmacist.
- QA activities provided by non-SPMP, which includes waivered or registered/waivered staff are **not**, at this time, eligible for Federal reimburse under this program.
- **Revised MHSA claiming rule: Staff on 100% MHSA funded items CAN claim to QA** the same as staff who are not associated with 100% MHSA funded items.

Specifically, what are QA Oversight Activities:

- Any of the activities listed on page seven. For your convenience, these activities are also briefly summarized on the bottom half of the QA Data Time Form.
-

Discuss any questions you may have with your supervisor. Remember, **you and your supervisor** are signing an audit document certifying that the claim is true and correct.

Who to call regarding QA Data Time Form data entry or claiming:

- Revenue Recovery Section, QA staff at (213) 738-4717.

What activities **are not** claimable QA Oversight Activities:

- Any activity that is not an oversight activity.
- Any activity that can be claimed as a direct service, regardless of payer source, i.e., Medi-Cal, SAMHSA (substance abuse), Family Preservation, etc. (Note - Reviewing a record as part of a direct service activity should continue to be claimed as direct service and **not** claimed as QA.)
- Any activity that can be claimed as MAA or COS.
- **The same period of time or activity claimed to another funding sources.** If you perform QA activities and claim them as such, **you must not** also record or claim that time or activity to MAA or COS or as a direct service.
- Supervision time, including clinical supervision, even though it may involve case review activities.
- Time spent conducting or attending staff meetings.
- Training time even if it's QA related – the only exception to this would be if you are being trained to be a trainer.
- Risk Management activities unless they are specifically related to reviewing the QA component of a situation.
- Transfer of Coordinator for non-open cases – claim as a MAA activity.
- Time beyond your regular scheduled work hours - your daily total time for **ALL** direct and indirect activities should not exceed your regular scheduled work hours.

Who to call for questions related to the QA activity definitions:

- Diane Guillory at (213) 738-3777, Program Support Bureau, Quality Assurance.
- If necessary, your questions will be forwarded to the State for clarification, and updates will be sent out to staff, as issues are resolved.

QUALITY ASSURANCE

ACTIVITY CHART

Quality Assurance Overview Activities*

	Service Type	Description of Activities	LA County Quality Assurance Applications
QA-1	Case Review	Time Spent in doing case review	Time spent in the review of a clinical record whether or not the case is open or close where the time is not appropriate for direct service billing and where major emphasis is on components of quality, including compliance with established documentation standards. Also includes time spent in appropriate follow-up action regarding areas of needed improvement. Please note this does not include supervision or phone messages.
QA-2	Quality Improvement Meeting	Quality Improvement Committee Meetings, preparation time, documentation (minutes), and follow-up	Time spent in the direct preparation of QA/QI materials for QIC meetings, traveling to the meetings, preparing notes/minutes from the meetings and follow up on QIC related items that would not be appropriate for any direct client billing. Also includes time spent in actions related to preparation, initiation and submission of appeals to the QIC for review.
QA-3	Training Time for Medi-Cal & QA Requirement	Training time and materials for Medi-Cal documentation requirements and associated QA activities and reviews	Time spent providing pre-Medi-Cal certification activities, formal trainings and technical assistance on interpretation of Medi-Cal/HIPAA documentation requirements as well as time spent on preparing training materials. Also includes time spent developing policies and forms to support this effort.
QA-4	Personnel Time Related to State & Federal QA Audit	Personnel time and materials for assisting State and Federal auditors with County audits for compliance with QA requirements	All time associated with the planning and gathering of materials and documentation to support State and Federal audit and review processes for compliance with County QA standards and requirements. Also includes travel time associated with support assisting the reviewers, time for entrance and exit conferences and follow up resolutions as per Plan of Corrections.
QA-5	Medication Monitoring	Medication monitoring and associated activities	Time associated with the development and review of policies and procedures to improve medication practices and processes related to efficient monitoring of medication as well as time spent monitoring. With the exception of supervision, this includes all the developmental, monitoring/review, and analysis activities noted here and in Policy 103.1, "Standards for Prescribing & Monitoring Medications", Sec 2.5, "Monitoring & QI".
QA-6	Develop Protocols	Developing protocols for review and Quality Improvement activities	Time spent in analysis or planning, such as HIPAA Gap Analysis, which leads to the development of policies and procedures, forms/logs etc., as part of QA/QI activities. An example of this is, creating or revising procedures and policies covering the storage and dispensing of meds.
QA-7	Overview of Service Providers	Overview of service providers who are also coordinators related to roles and QA requirements	Time spent in meetings and trainings related to the functions of coordinators that are directly tied to improving QA. Also includes time spent in: creating and implementing the use of new or revised forms that support coordination efforts; engaging in program level review, actual Medi-Cal certification activities and other oversight activities, such as monitoring and follow-up activities with contract providers, for compliance with County quality of care standards.

* See "Examples of Non-reimbursable QA Oversight Activities" for additional clarification.

2/3/03
Revised 11/21/08

INSTRUCTIONS

FOR COMPLETION OF THE

QUALITY ASSURANCE

DATA TIME

FORM

COMPLETING THE QA DATA TIME FORM

The QA Data Time Form designed in Microsoft Excel allows staff to either:

- Create a printable master copy after entering the Clinic name and Provider Number, Staff Name and Employee Number, and SPMP status on the form. This master copy can be photocopied for the **semi-monthly** submittal of the forms, OR
- Input all data in the form on your computer, then print the form.

Completing the form:

- Whenever SPMP staff performs County QA oversight claimable activities, s/he should enter the activity data in the yellow highlighted shaded area. No data entry is needed on days that QA activities are not performed.
- Since the QA Data Time Form is designed for semi-monthly recording of QA activities, two (2) separate forms are needed to record a month of services. In addition to checking the **date range box** that indicates if services were provided on the 1st through the 15th or the 16th through the 31st of the month; staff need to **circle** each day(s) of services (see sample on pages 12 and 13).
- In the right column, make notes that will assist you in recalling the specific QA Activity that you performed. Additional space is provided on the back of the form for detailed notes, if necessary, to ensure that your QA Data Time is adequately documented.
- If you enter data on your hard copy, subtotal both your daily and semi-monthly time. If you enter data on your Excel worksheet, daily time totals and semi-monthly time totals are automatically calculated.

Required signatures:

- Staff and supervisor original signatures in **ink** must be recorded on each QA Data Time Form.

When and where to send completed claim forms:

- For each two week time period, forms must be submitted within 2 weeks after the 15th or the last day of the month.
- Mail the forms as instructed on the bottom of the form.

County of Los Angeles - Department of Mental Health
Quality Assurance (QA) Data Time Form

Employee Name: _____ Employee #: _____

Clinic Name: _____ Clinic Provider #: _____ Cost Center (Unit Code) from Time Card: _____

SPMP - The following are Licensed Skilled Professional Medical Personnel and as such can claim these QA activities (1) Physician (2) Psychiatrist (3) Psychologist (4) R.N., (5) MFT (6) LCSW & (7) Pharmacist.
The Federal government does not accept waiver or registered staff status for claiming Quality Assurance.

Check your California licensure: ☐ Physician ☐ Psychiatrist ☐ Psychologist ☐ RN ☐ MFT ☐ LCSW ☐ Pharmacist

Date Range (must check one):
☐ 1-15 ☐ 16-31 _____ / _____
Month Year

Circle Date		Minutes total/day	QA-1 Minutes	QA-2 Minutes	QA-3 Minutes	QA-4 Minutes	QA-5 Minutes	QA-6 Minutes	QA-7 Minutes	Remarks/Notes
	16	0								
1	17	0								
2	18	0								
3	19	0								
4	20	0								
5	21	0								
6	22	0								
7	23	0								
8	24	0								
9	25	0								
10	26	0								
11	27	0								
12	28	0								
13	29	0								
14	30	0								
15	31	0								
Total minutes:		0	0	0	0	0	0	0	0	

Quality Assurance Activities:

	Service Type	Description of Activities
QA-1	Case Review	Time Spent in doing case review, and in reviewing client records for compliance LA County Note: Reviewing a record that results in a service, such as preparing clinically for a session with a client, should continue to be claimed as direct service and **Not** duplicated here.
QA-2	Quality Improvement Meeting	Quality Improvement Committee Meetings, preparation time, documentation (minutes), and follow-up.
QA-3	Training Time for Medi-Cal & QA Requirement	Training time and materials for Medi-Cal documentation requirements and associated QA activities and reviews.
QA-4	Personnel Time Related to State & Federal QA Audit	Personnel time and materials for assisting State and Federal auditors with County audits for compliance with QA requirements.
QA-5	Medication Monitoring	Medication monitoring and associated activities (Refer to Standards for prescribing and monitoring medications Policy 103.1 section 2.5)
QA-6	Develop Protocols	Developing protocols for review and Quality Improvement activities.
QA-7	Overview of Service Providers	Overview of service providers who are also coordinators related to roles and QA requirements.

I HEREBY CERTIFY under penalty of perjury that I am the staff responsible for preparing this QA Data Time Form and I have not violated any of the provisions of Section 1090 through 1098 of the Government Code that the amount of time for which reimbursement is claimed herein is in accordance with Chapter 3, Part 2, Division 5 of the Welfare and Institutions Code and to the best of my knowledge and belief this claim is in all respects true, correct and in accordance with law.

Employee Signature: _____ Date: _____ Supervisor Signature: _____ Date: _____

Filing instructions:

Mail to: **Department of Mental Health - RASD**
Revenue Recovery Section
550 S. Vermont Ave, 11th floor
Los Angeles, CA 90020
Attn: QA Desk

For questions regarding this claim form, contact:
Revenue Recovery Section **213-738-4752**
For QA Activity definition contact:
Diane Guillory **213-251-6809**

Retention Instructions: Maintain a copy on file for 7 years.

County of Los Angeles - Department of Mental Health

Quality Assurance (QA) Data Time Form - Remark (Optional)

Employee Name: _____

Employee #: _____

Clinic Name: _____

Clinic Provider #: _____

Date Range (must check one):

☐ 1-15 ☐ 16-31 _____ / _____

Month Year

Cost Center (Unit Code) from Time Card: _____

Date	Remarks/Notes

Note: Attached to QA form if applicable

County of Los Angeles - Department of Mental Health
Quality Assurance (QA) Data Time Form

Employee Name: Norman Doe Employee #: 234566

Clinic Name: DMH-HDG Clinic Provider #: 6789A Cost Center (Unit Code) from Time Card: 12345

SPMP - The following are Licensed Skilled Professional Medical Personnel and as such can claim these QA activities (1) Physician (2) Psychiatrist (3) Psychologist (4) R.N., (5) MFT (6) LCSW & (7) Pharmacist.
The Federal government does not accept waiver or registered staff status for claiming Quality Assurance.

Check your California licensure: ☐ Physician ☐ Psychiatrist ☐ Psychologist ☑ RN ☐ MFT ☐ LCSW ☐ Pharmacist

Date Range (must check one): ☑ 1-15 ☐ 16-31 September (Month) / 2008 (Year)

Circle Date		Minutes total/day	QA-1 Minutes	QA-2 Minutes	QA-3 Minutes	QA-4 Minutes	QA-5 Minutes	QA-6 Minutes	QA-7 Minutes	Remarks/Notes
	16	0								
(1)	17	15					15			Report to chief MD on PATS Exceptions
2	18	0								
3	19	0								
4	20	0								
5	21	0								
6	22	0								
7	23	0								
8	24	0								
(9)	25	35						35		Review & comment - revised draft policy
10	26	0								
11	27	0								
12	28	0								
13	29	0								
14	30	0								
(15)	31	60			60					Trained staff on claiming QA
Total minutes:		110	0	0	60	0	15	35	0	

Quality Assurance Activities:

	Service Type	Description of Activities
QA-1	Case Review	Time Spent in doing case review, and in reviewing client records for compliance. LA County Note: Reviewing a record that results in a service, such as preparing clinically for a session with a client, should continue to be claimed as direct service and Not duplicated here.
QA-2	Quality Improvement Meeting	Quality Improvement Committee Meetings, preparation time, documentation (minutes), and follow-up.
QA-3	Training Time for Medi-Cal & QA Requirement	Training time and materials for Medi-Cal documentation requirements and associated QA activities and reviews.
QA-4	Personnel Time Related to State & Federal QA Audit	Personnel time and materials for assisting State and Federal auditors with County audits for compliance with QA requirements.
QA-5	Medication Monitoring	Medication monitoring and associated activities (Refer to Standards for prescribing and monitoring medications Policy 103.1 section 2.5)
QA-6	Develop Protocols	Developing protocols for review and Quality Improvement activities.
QA-7	Overview of Service Providers	Overview of service providers who are also coordinators related to roles and QA requirements.

I HEREBY CERTIFY under penalty of perjury that I am the staff responsible for preparing this QA Data Time Form and I have not violated any of the provisions of Section 1090 through 1098 of the Government Code that the amount of time for which reimbursement is claimed herein is in accordance with Chapter 3, Part 2, Division 5 of the Welfare and Institutions Code and to the best of my knowledge and belief this claim is in all respects true, correct and in accordance with law.

Employee Signature: Date: 9/15/2008 Supervisor Signature: Date: 9/20/2008

Filing instructions:

Mail to: **Department of Mental Health - RASD**
Revenue Recovery Section
550 S. Vermont Ave, 11th floor
Los Angeles, CA 90020
Attn: QA Desk

For questions regarding this claim form, contact:
Revenue Recovery Section 213-738-4752
For QA Activity definition contact:
Diane Guillory 213-251-6809

Retention Instructions: Maintain a copy on file for 7 years.

County of Los Angeles - Department of Mental Health
Quality Assurance (QA) Data Time Form

Employee Name: Norman Doe Employee #: 234566

Clinic Name: DMH-HDG Clinic Provider #: 6789A Cost Center (Unit Code) from Time Card: 12345

SPMP - The following are Licensed Skilled Professional Medical Personnel and as such can claim these QA activities (1) Physician (2) Psychiatrist (3) Psychologist (4) R.N., (5) MFT (6) LCSW & (7) Pharmacist.
The Federal government does not accept waiver or registered staff status for claiming Quality Assurance.

Check your California licensure: ☐ Physician ☐ Psychiatrist ☐ Psychologist ☑ RN ☐ MFT ☐ LCSW ☐ Pharmacist

Date Range (must check one):
☐ 1-15 ☑ 16-31 September (Month) / 2008 (Year)

Circle Date		Minutes total/day	QA-1 Minutes	QA-2 Minutes	QA-3 Minutes	QA-4 Minutes	QA-5 Minutes	QA-6 Minutes	QA-7 Minutes	Remarks/Notes
	16	0								
1	(17)	25					25			Review of PATS Exception Rpt & associated paperwork
2	18	0								
3	19	0								
4	20	0								
5	21	0								
6	22	0								
7	23	0								
8	24	0								
9	25	0								
10	(26)	360	60			300				See back of form
11	27	0								
12	28	0								
13	(29)	35							35	TC to 2 providers to discuss implementation of new SP
14	30	0								
15	31	0								
Total minutes:		420	60	0	0	300	25	0	35	

Quality Assurance Activities:

	Service Type	Description of Activities
QA-1	Case Review	Time Spent in doing case review, and in reviewing client records for compliance. LA County Note: Reviewing a record that results in a service, such as preparing clinically for a session with a client, should continue to be claimed as direct service and **Not** duplicated here.
QA-2	Quality Improvement Meeting	Quality Improvement Committee Meetings, preparation time, documentation (minutes), and follow-up.
QA-3	Training Time for Medi-Cal & QA Requirement	Training time and materials for Medi-Cal documentation requirements and associated QA activities and reviews.
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QA-5	Medication Monitoring	Medication monitoring and associated activities (Refer to Standards for prescribing and monitoring medications Policy 103.1 section 2.5)
QA-6	Develop Protocols	Developing protocols for review and Quality Improvement activities.
QA-7	Overview of Service Providers	Overview of service providers who are also coordinators related to roles and QA requirements.

I HEREBY CERTIFY under penalty of perjury that I am the staff responsible for preparing this QA Data Time Form and I have not violated any of the provisions of Section 1090 through 1098 of the Government Code that the amount of time for which reimbursement is claimed herein is in accordance with Chapter 3, Part 2, Division 5 of the Welfare and Institutions Code and to the best of my knowledge and belief this claim is in all respects true, correct and in accordance with law.

Employee Signature: _____ Date: 9/30/2008 Supervisor Signature: _____ Date: 10/2/2008

Filing instructions:

Mail to: **Department of Mental Health - RASD**
Revenue Recovery Section
550 S. Vermont Ave, 11th floor
Los Angeles, CA 90020
Attn: QA Desk

For questions regarding this claim form, contact:
Revenue Recovery Section **213-738-4752**
For QA Activity definition contact:
Diane Guillory **213-251-6809**

Retention Instructions: Maintain a copy on file for 7 years.

County of Los Angeles - Department of Mental Health

Quality Assurance (QA) Data Time Form - Remark (Optional)

Employee Name: Norman Doe

Employee #: 234566

Clinic Name: DMH-HDQ

Clinic Provider #: 6789A

Date Range (must check one):

☐ 1-15 ☑ 16-31 September / 2008
Month Year

Cost Center (Unit Code) from Time Card: 12345

Date	Remarks/Notes
Sept. 26	QA-1 Weekly review of 10 cases for compliance; QA-4 Attended pre-audit conference, travel

Note: Attached to QA form if applicable.